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No. OFFICE OF THE CLERK

In The

Supreme Court of the United States

October Term, 1997

RONALD MARTIN, Administrator of the Estate of Nancy Martin, Deceased,

Petitioner,

vs.

BLUE CROSS BLUE SHIELD OF VIRGINIA,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Is the "full and fair review" guaranteed by 29 U.S.C. § 1133 of ERISA violated when the Plan refuses to send the Plan language relied on in the denial, refuses to send the basis for the denial, and relies on materials not disclosed to the participant in denying the claim?

2. The second question presented is whether in an ERISA case a reviewing court interpreting an exclusion may depart from the specific language of the exclusion to improvise its own exclusionary criteria?

PARTIES TO THE PROCEEDINGS

Petitioner Ronald Martin is an individual and Administrator of the Estate of Nancy Cornelius Martin, Deceased.

Respondent is Blue Cross and Blue Shield of Virginia, Inc., a publicly held corporation with its principal place of business at 2015 Staples Mill Road, Richmond, Virginia 23279.

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Petitioner, Ronald Martin, an individual as Administrator of the Estate of Nancy Cornelius Martin, respectfully prays that this Court issue a writ of certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit entered on June 23, 1997.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fourth Circuit in the appeal in *Martin v. Blue Cross & Blue Shield of Virginia*, Docket No. 96-1534 (4th Cir. 1996), is reported at *Martin v. Blue Cross and Blue Shield of Virginia*, 114 F.3d 1201 (4th Cir. 1997). The decisions of the United States District Court for the Western District of Virginia are docketed as Civil Action No. 94-0081-C.

STATEMENT OF JURISDICTION

Petitioner Martin seeks to invoke the jurisdiction of this Court under 28 U.S.C. § 1254(1) to review by writ of certiorari the Order of the United States Court of Appeals for the Fourth Circuit dated June 23, 1997, which reversed the trial court's decisions and awarded judgment in favor of Respondent Blue Cross & Blue Shield of Virginia. Petitioner Martin's Petition for Rehearing was denied by the United States Court of Appeals for the Fourth Circuit on July 22, 1997. Pursuant to Supreme Court Rule 13.3, this petition was timely filed within 90 days from the date of the denial of the Petition for Rehearing.

STATUTORY PROVISIONS INVOLVED

Petitioner respectfully refers the Court to the Appendix materials.

CONCISE STATEMENT OF THE CASE

This case involves Nancy Cornelius Martin's claim under the Employee Retirement Income Security Act (ERISA) 29 U.S.C.A. § 1001, *et seq.* (West 1985 & Supp. 1997), to obtain insurance coverage for the high dose chemotherapy treatment with peripheral stem cell rescue (HDCT) she underwent in 1994 to treat her epithelial ovarian cancer. Mrs. Martin was insured as a beneficiary through her husband's business, Ray Fisher and Ron Martin, Inc., (the Company). In October of 1993, the Company contracted with the Respondent, Blue Cross and Blue Shield of Virginia (the Plan) to provide the Company's health insurance and to administer the insurance policy. (App. at 4a).

In 1994, Mrs. Martin was diagnosed with ovarian cancer and was referred to Dr. Steven Wolff of Vanderbilt University Medical Center (Vanderbilt). Dr. Wolff recommended that Mrs. Martin undergo HDCT as the best available therapy for her cancer. On April 27, 1994, and again on June 6, 1994, Dr. Wolff requested pre-authorization for the treatment from the Plan. The Plan denied coverage for both requests on a pre-printed form, checking a box which stated "[s]ervice is not covered under the patient's benefit program." Another box which stated "Investigational (experimental) treatments are not covered" was not checked on either form. The comments on the denials stated the therapy was considered "investigational."

Mrs. Martin appealed the denials on July 6, 1994, including several medical articles on the effectiveness of the recommended treatment for ovarian cancer. In addition, her counsel made a formal request pursuant to 29 U.S.C. § 1133 for a current copy of the insurance policy, the current SPD, and any other information the Plan required in evaluating the claim. (App. at 6a). Blue Cross denied the appeal on August 2, 1994, stating the treatment did not meet the Plan's "coverage eligibility

guidelines." (App. at 7a). Attached to the letter was a one page document listing five factors entitled "Coverage Eligibility Guidelines." (App. at 7a). Mrs. Martin underwent the procedure in 1994 even though Blue Cross denied coverage.

On November 28, 1994, Mrs. Martin filed this action against the Plan in the Western District of Virginia. Her complaint set out two counts; one for violation of 29 U.S.C. § 1133 and one for a declaratory judgment for benefit coverage under 29 U.S.C. § 1132. The magistrate judge bifurcated the trial to determine first, whether Mrs. Martin received a copy of the policy, and if not, whether the policy or the summary plan description (SPD) controlled. (App. at 7a).

On July 5, 1995, the magistrate judge ruled that the Company never received a copy of the policy and concluded the SPD controlled. On December 13, 1995, a second trial was conducted to determine if Mrs. Martin's treatment was covered under the terms of the SPD. Because the SPD did not reserve discretion to the Plan, the standard of review was *de novo*. In a memorandum opinion issued on January 22, 1996, the magistrate judge ruled the treatment was not experimental or investigative under the Plan's coverage eligibility guidelines. (App. at 38a). The court stated the testimony of Mrs. Martin's expert witness, Dr. Wolff, was "clear, unambiguous, and much more believable than the testimony of defendant's representative, Dr. Colley, and it will be credited over that of Dr. Colley." (App. at 38a).

The Plan appealed the rulings of the district court to the United States Court of Appeals for the Fourth Circuit, claiming the procedure was excluded under the policy's and the SPD's exclusions for investigative/experimental as well as another exclusion in the Plan and the SPD for autologous bone marrow transplants. On appeal, the Fourth Circuit reversed and held that the treatment was experimental or investigative based on the

exclusion contained in the policy, not the SPD. The Fourth Circuit also reversed the district court's holding that the SPD controlled the case. (App. at 9a). Therefore, the Fourth Circuit applied the deferential standard of review, modified to reflect the Plan administrator's conflict of interest. (App. at 13a).

The court concluded remand was not necessary because it found the procedure was experimental as a matter of law. The court concluded the Plan was not unreasonable in denying the claim based upon a finding that the Plan extensively reviewed the medical literature before denying Mrs. Martin's application for coverage. (App. at 15a). The court cited two articles relied upon by the Plan in denying coverage, and concluded the Plan was reasonable in denying coverage based on its review of those articles.

Although Mrs. Martin raised the 29 U.S.C. § 1133 violations in her brief to the Fourth Circuit, the court did not address the violations in its opinion. The basis for federal jurisdiction in the district court was founded upon the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001, *et seq.*

REASONS FOR GRANTING THE WRIT

I.

THIS COURT SHOULD GRANT CERTIORARI TO ENSURE PROPER ENFORCEMENT OF 29 U.S.C. § 1133 TO REDUCE ERISA LITIGATION.

The first question presented to this Court is whether Plans are permitted to violate 29 U.S.C. § 1133, and are permitted to rely on information not disclosed to participants during the administrative review process, or whether information relied on

but not revealed by Plans to participants as required by 29 U.S.C. § 1133 will not be considered on review because the procedural due process safeguards necessary to create a balanced record have not been met. The Fourth Circuit's ruling in this case conflicts with other circuit court decisions involving violations of 29 U.S.C. § 1133. This case provides the Court with an opportunity to advise lower courts on proper enforcement of 29 U.S.C. § 1133 for the protection of participants and to thereby diminish the number of ERISA claims that are litigated in federal courts.

In *Firestone v. Bruch*, 489 U.S. 101 (1989), this Court emphasized Congress' purpose in enacting the ERISA disclosure provisions was to ensure "that the individual participant knows exactly where he stands" *Id.* at 103. Based on this recognition of purpose, the Court also noted in *Firestone* that it would be senseless to create federal common law under ERISA "that would afford less protection to [participants] and beneficiaries than they enjoyed before ERISA was enacted." *Id.* at 112. Several federal courts have reiterated ERISA was enacted to promote internal resolution of claims without the expense and delay of the courts. The Fourth Circuit's ruling in this case undermines ERISA's fundamental principles and for this reason certiorari must be granted.

Here, the Fourth Circuit held that the Plan was reasonable in denying Mrs. Martin's claim based on its finding that the Plan reviewed medical literature before sending out the final denial letter. However, the court of appeals ignored several § 1133 violations, including the Plan's admission at trial that it ignored Mrs. Martin's written request for the Plan documents, that the denial letters did not contain essential information required under ERISA, and that articles were relied on but not identified by the Plan during the administrative review, despite a formal request for such information pursuant to 29 U.S.C.

§ 1133. These articles were cited to by the court of appeals as supporting the reasonableness of the Plan's denial. Proper construction of 29 U.S.C § 1133 mandates that information a Plan relies on but does not disclose falls outside ERISA's statutory scheme for review known as the "record". In drafting ERISA, Congress stated that it would enable an individual to know,

> exactly where he stands with respect to the plan — what benefits he may be entitled to, what circumstances may preclude him from obtaining benefits, what procedures he must follow to obtain benefits, and who are the persons to whom the management and investment of his plan funds have been entrusted

See S. Rep. 93-127 at 11; H.R. Rep. 93-533 at 8. As part of a cohesive statutory scheme, these disclosure requirements were designed to work in tandem with ERISA's fiduciary standards, which impose on fiduciaries strict duties of loyalty and care. These duties include acting solely in the interests of participants for the exclusive purpose of providing benefits to participants and their beneficiaries. 29 U.S.C. § 1103(c)(1) and 29 U.S.C. § 1104(a)(1)(A). In recognition of Congress' intent that ERISA reduce litigation over benefits, the federal courts have construed the provisions of ERISA to require a beneficiary to exhaust administrative remedies before filing a suit for benefits in court. *Makar v. Health Care Corporation of the Mid-Atlantic*, 872 F.2d 80, 82-83 (4th Cir. 1989). The rationale behind the exhaustion requirement is to require a complete administrative review short of the court system. This overall statutory scheme was intended to provide individuals "with enough information to enforce their own rights as well as the obligations owed by the fiduciary to the plan in general" during the administrative process, *before* filing a lawsuit. *See* S. Rep. 93-127 at 27; H.R. Rep. 93-533; at 11.

Frequently plans are afforded the deferential arbitrary and capricious standard of review, meaning that a district court will not overturn a Plan's denial where it appears to be reasonable, even where the court would have reached a different result. *Doe v. Group Hospitalization & Medical Services*, 3 F.3d 80, 85 (4th Cir. 1994). While this standard appears at odds with the fiduciary standards set out above, the statutory structure of ERISA remains well balanced due to the disclosure requirements contained in 29 U.S.C. § 1133 guaranteeing participants the right to a "full and fair review." In this sense, § 1133 and the regulations, when properly followed, insure that claimants have a genuine opportunity to present their case, and have access to relevant information necessary to appeal the denial of benefits. *Halpin v. Grainger*, 962 F.2d 685, 689 (7th Cir. 1992). At the same time, Plans may conduct claims reviews in a non-adversarial environment. When ERISA's provisions work together as Congress intended, both participants and plans are provided with due process protections and the need for judicial intervention is diminished.

Central to these protections are the minimum disclosure requirements mandated in § 1133. In short, ERISA requires Plans to conduct a "full and fair review" for each claim denied. Pursuant to 29 U.S.C. § 1135, the Secretary of Labor is empowered by Congress to enforce the disclosure and reporting requirements of ERISA. Accordingly, the Secretary's regulations require that essential information be provided to participants when claims are denied in the administrative review procedure. 29 C.F.R. § 2560.503-1(f). In order to ensure that Plans conduct a "full and fair" review of each claim, the Secretary's regulations require the following information be provided with the initial denial of benefits: (1) the specific reason for the denial; (2) specific reference to the pertinent plan provisions upon which the denial is based; (3) a description of any additional information necessary for the claimant to perfect the claim with

an explanation of why such information is necessary; and (4) information on the steps the claimant must take to submit the claim for review. *See* 29 C.F.R. § 2560.503-1(f).

The three claims denials sent to Mrs. Martin did not contain the information required by § 1133 and the regulations. The first two denials were sent on pre-printed forms, stating only that the therapy was considered "investigational". The letters did not set out the specific reason for the denial, as they did not check the investigative/experimental box as the reason for the denial. The letters did not state the specific plan provision the denial was based upon, no plan language was cited whatsoever. The letters did not inform Mrs. Martin of her appeal rights, rather the pre-printed information stated "[f]or additional coverage information, please contact our Provider Inquiry Unit."

The final denial letter did not cure any of the notice defects. It stated that the Technology Evaluation and Coverage (TEC) program of the Blue Cross and Blue Shield Association reviewed "all of the scientific published peer reviewed literature on ABMT for treating epithelial ovarian cancer." This letter does not identify the reason for the denial or reference any Plan provision; the words investigational or experimental do not appear in the letter. The letter does not tell Mrs. Martin she has the right to an appeal, does not describe any additional information she could submit, and does not tell her what "literature" was reviewed in denying the claim. However, the Fourth Circuit completely ignored these § 1133 violations.

The Fourth Circuit's decision conflicts with that in *Wolfe v. J.C. Penney Co., Inc.*, 710 F.2d 388, 393 (7th Cir. 1983), where the Seventh Circuit held such violations of section 1133 are impermissible. The court stated the regulations' requirement of specifying the pertinent plan provision is "essential for the participant to fully apprehend the reason for the denial and to

know what deficiency in his application must be overcome." *Id.* at 391. The *Wolfe* court concluded that the Plan's denial ". . . misses the 1133 target. The 'reason' given for the denial is not a reason but a conclusion." *Id.* at 392. The same is true here — Mrs. Martin was only told the Plan's conclusions, not its reasons. All of the § 1133 violations addressed by the court in *Wolfe* occurred here, however the Fourth Circuit ignored the errors, creating a conflict among the circuits as to the proper enforcement of 29 U.S.C. § 1133.

The Sixth Circuit has also agreed such § 1133 violations merit a remedy. In *VanderKlok v. Provident Life and Acc. Ins. Co.*, 956 F.2d 610 (6th Cir. 1992), the court agreed with the court in *Wolfe*, *supra*, that the § 1133 violations where significant errors on questions of law that required the decision to deny benefits be overturned. *Id.* at 616. The court held that because Provident failed to follow § 1133, it was not entitled to the protections concerning administrative review. Therefore, the court ruled remand was not required. *Id.* at 617. As such, the Fourth Circuit's ruling in this case also conflicts with the Sixth Circuit as to the proper interpretation of § 1133. It is clear courts require definitive instruction as to proper enforcement of 29 U.S.C. § 1133 as part of ERISA's statutory scheme.

The Secretary of Labor's regulations also make clear the Secretary's intent that participants have access to all *documents* relevant to the review procedure. The Secretary's regulations require that all claims procedures maintained by plans contain provisions allowing participants to "(i) Request a review upon written application to the plan; (ii) *Review pertinent documents*; and (iii) Submit issues and comments in writing." 29 C.F.R. § 2560.503-1(g)(1). (Emphasis added). By design, these regulations work together with the courts' requirement that participants exhaust administrative remedies before filing suit, as they require the Plan to reveal all relevant information and

documents to the participant during the administrative process. This enables the participant, who is so required, to exhaust remedies meaningfully at the administrative level. As stated in *Weaver v. Phoenix Home Life Mutual Ins. Co.*, 990 F.2d 154, 157 (4th Cir. 1993), "[t]hese procedural guidelines are at the foundation of ERISA," noting the guidelines play an important role in achieving Congress' intent that Plans and participants resolve disputes internally.

Mrs. Martin's counsel made a formal request pursuant to § 1133 for the plan documents and information relied on during the administrative process. The Plan admitted at trial it received Mrs. Martin's § 1133 request but never responded to it. The Plan did not send the Plan document or the current SPD as requested. The Plan did not tell Mrs. Martin that it relied on two articles in denying her claim on an experimental/ investigative basis until the second district court trial,[1] even though this information was requested during the administrative review and during discovery.

The Plan did not state in the final denial letter that articles existed or that the Plan relied on any such articles in denying the claim — rather the letter stated "[t]he treatment modality does not meet our coverage eligibility guidelines. I have enclosed

1. The articles were produced in discovery one day prior to the deposition of the Plan's expert witness, Dr. McGuire, as supporting his expert opinions. However, Dr. McGuire did not participate in the administrative review of this claim. The fact that Dr. McGuire may have relied on the articles in forming his opinions does not by extension mean the Plan can claim proper reliance on these materials; the Plan's administrative review occurred prior to Dr. McGuire's involvement in the claim. Dr. McGuire was stricken as an expert in the case, therefore the articles were not properly admissible at trial under such holdings as *Masella v. Blue Cross & Blue Shield of Conn.*, 936 F.2d 98 (2nd Cir. 1991) for purposes of plan interpretation. In addition, these articles were properly objected to at trial. (J.A. 564-565).

a copy of those for your review." Therefore, the only *document* identified was the coverage eligibility guidelines, which Mrs. Martin's oncologists advised did not apply to her treatment.

The Fourth Circuit noted that the Medical Director for the Plan, Dr. Colley,[2] "had seen the NIH statement" when the denial was made. (App. at 56). However, the Plan did not tell Mrs. Martin the document was reviewed or relied on in denying her claim. How was Mrs. Martin supposed to have the full and fair review envisioned by 29 U.S.C. § 1133 when the Plan never told her the reason for her denial? Why can a Plan rely on documents it will not allow the participant to rebut?

Nondisclosure of these documents was in violation of § 1133. The regulations require that the Plan tell the participant any additional information needed to perfect the claim with an explanation of why the information is necessary. In this case, that would have meant telling Mrs. Martin which journal articles and other information were relied on in denying her claim, thereby allowing her to submit any other medical information which would serve to rebut that provided to her by the Plan. Under ERISA, identification of the documents comprising the administrative record in the claims denial is intended to prevent such nondisclosure.

Considering these articles on review conflicts with decisions in the Third, Seventh and Fourth Circuits in failing to enforce the requirements of 29 U.S.C. § 1133. *See Grossmuller v. International Union, et al.*, 715 F.2d 853, 858 (3rd Cir. 1981); *Halpin v. Grainger*, *supra*; *Weaver v. Phoenix Home Life Mutual Insurance Co.*, *supra*. In *Halpin v. Grainger*, 962 F.2d at 689, the court stated a full and fair review requires knowing what

2. The Fourth Circuit incorrectly identified Dr. Colley as an expert witness. *See* Opinion at 11. Dr. Colley did not testify as an expert witness. The Plan did not put on any expert testimony at trial.

evidence the decision-maker relied upon and having an opportunity to address the accuracy and reliability of that evidence. The court held these requirements enable the claimant to prepare adequately ". . . for any further administrative review, as well as appeal to the federal courts." *Id.* In *Grossmuller, supra*, the court stated the decision-maker must consider the position of both sides before rendering the decision, ". . . and may impose upon him the duty to develop a complete and impartial record." *Id.* at 838. Here, Mrs. Martin was not told these articles were relied on, and therefore never had the opportunity to rebut the articles or to submit additional materials of her own. Because the articles were withheld from Mrs. Martin for her consideration and rebuttal, they are repugnant to ERISA's notion of a complete and impartial record upon which judicial review may be based.

Allowing undisclosed information to come into evidence invites inequitable results. The Plan stated at trial it relied on these articles, yet Mrs. Martin was precluded under the rules of deferential review from providing her own information to rebut that of the Plan's. Recall that this "secret record" was first sprung upon her at trial. Several circuit courts have held that a district court's review is limited to information which was before the plan administrator at the time the denial was rendered, whether the standard of review is *de novo* or deferential. *Berry v. Ciba-Geigy Corp*, 761 F.2d 1003, 1007 (4th Cir. 1985); *Perry v. Simplicity Engineering*, 900 F.3d 963 (6th Cir. 1990); *Davidson v. The Prudential Co. of America*, 953 F.2d 1093 (8th Cir. 1992); *Wolfe v. J.C. Penney Co., Inc.*, 710 F.2d 388, 394 (7th Cir. 1983). In application, this rule ordinarily means that a participant who fails to present evidence to the plan administrator during the administrative review generally will not be permitted to introduce that evidence for the first time to the district court. In *Perry, supra*, the court held that a primary goal of ERISA was to provide a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously. *Id.* at

967. Therefore, the court concluded that permitting or requiring district courts to consider evidence from **both parties** that was not presented to the plan administrator would seriously impair the achievement of the goal. *Id.* at 967.

Martin submits to this Court that this rule must also be applied to Plans where they hold the decision making power[3]. Information not identified to *both sides* as supporting the claims determination, when the parties have exercised their rights under ERISA to request and review such information, is not properly admissible in the district court on review.

No one questions that an administrative decision cannot be challenged based upon information never presented at the administrative levels — such information simply never becomes a part of the "record". Permitting Plans to rely on a "secret record" developed behind the participant's back undermines the entire statutory scheme of ERISA. How is a participant exhausting administrative remedies to address an administrator's secret record?

This ruling will also needlessly increase litigation. In this case, had the Plan identified the required information, two different results might have occurred. Mrs. Martin, her lawyer,

3. The Plan argued in the district trial that by operation of law Mrs. Martin's husband was the plan administrator. However, documents not provided to the "plan administrator" cannot be considered. *Berry v. Ciba-Geigy, supra*, 761 F.2d at 1007. The proper interpretation of the term "plan administrator" for this purpose is whomever has the decision making authority over the claim. Mr. Martin did not have authority to override the Plan and require payment of the benefits. As the Secretary's regulations make clear, in situations where benefits are provided for or administered by an insurance company, the insurance company shall be the "appropriate named fiduciary" for purposes of the review procedure. 29 C.F.R. § 2560.503-1(g)(2). Here the benefits are provided by an insurance company, Trigon Blue Cross Blue Shield, the Plan.

and her doctors could have rebutted the information and changed the Plan's mind. Conversely, they might have reviewed it and decided they could *not* rebut the information, in which case the litigation ***never would have gone forward***. The court in *Wolfe, supra*, 710 F.2d at 388, recognized this in reference to the § 1133 violations, holding that if the Plan had complied with § 1133, Wolfe would have supplemented the record, sought and received a full and fair review ". . . before the Board of Governors, and obtained a decision one way or another based upon substantial evidence." If Plans are allowed to hold information in reserve for trial, participants cannot intelligently decide whether the denials are reasonable. How can participants decide whether they should pursue legal remedies? Under the Fourth Circuit's ruling, they cannot, which is completely contrary to Congress' intent in drafting ERISA.

Based on the rulings of *VanderKlok*, *Wolfe*, *Halpin*, *Grossmuller*, and *Weaver*, emphasizing the central role § 1133 plays in ERISA's statutory scheme, and based upon the analysis of the scope of review in *Perry*, and similar cases, the policy underlying development of an administrative record mandates that evidence not made available for consideration by the participant cannot be deemed to be part of the record. If this Court instructs the federal courts to enforce § 1133, Mrs. Martin, and many others, will be given the information necessary to make intelligent choices about their benefit denials when they are supposed to, during the claims review process.

II.

THIS COURT SHOULD GRANT CERTIORARI TO INSTRUCT LOWER COURTS ON HOW TO PROPERLY APPLY PLAN TERMS IN ERISA CASES.

Under ERISA, fiduciaries cannot impose terms not contained in the plan documents. The second question presented to this Court is whether a federal court reviewing an ERISA denial can properly apply a new term of exclusion not contained in the language of the Plan. *McElroy v. United States*, 455 U.S. 642, 643 (1982); *Marks v. United States*, 430 U.S. 188, 189 (1977). This issue presents the Court with an opportunity to instruct ERISA fiduciaries and federal courts on how to properly apply plan terms in ERISA cases.

The district court ruled the treatment at issue in the case was not experimental based on the expert witness testimony discussing the terms of the Plan in relation to the treatment at issue. In reversing the trial court's decision, the Fourth Circuit departed from the language of the Plan and applied a new definition of "experimental". As previously recognized by the Fourth Circuit and others, a *fiduciary* may not disregard plan terms, nor may it impose new plan terms. *Epright v. Environmental Resources Management*, 81 F.3d 335, 342 (3rd Cir. 1996); *Wilson v. CHAMPUS*, 65 F.3d 361, 366 (4th Cir. 1995); *Sheldon v. Barne Belt Granite Employer Union Pension Fund*, 25 F.3d 74 (2d Cir. 1994); *Heasley v. Belden & Blake Corp.*, 2 F.3d 1249, 1261 (3rd Cir. 1993). Therefore, the issue presented to this Court for certiorari is whether this prohibition against going beyond the written plan terms should be extended to reviewing courts.

In reversing the district court, the Fourth Circuit imposed a definition of "experimental" not found within the Plan. Mrs.

Martin's Plan contained exclusionary language stating that the Plan excludes "[a]ny service determined to be Experimental/ Investigative by the Company, in its sole discretion." (App. at 9a). The Plan further defined "experimental/ investigative" by setting out four criteria, the last of which stated, "the service or supply must be as safe and effective outside a research setting as current diagnostic or therapeutic options." (App. at 10a). Under this definition, the district court found that the treatment was not excluded from coverage. (App. at 38a). The Fourth Circuit reversed based on its conclusion that the treatment was "investigative/experimental" in reference to the fourth criteria of the exclusion.[4]

The Fourth Circuit relied on testimony from Mrs. Martin's expert, Dr. Wolff. Yet, Dr. Wolff testified that the treatment *met* the fourth criteria of the exclusion. In fact, the Fourth Circuit acknowledged in the opinion that Dr. Wolff's testimony established the procedure was not experimental or investigative under the criteria as written in the exclusion. (App. at 17a). However, the Court refused to apply this expert testimony to sustain coverage.

In finding that the fourth exclusion applied to deny coverage for the treatment, the Court relied on Dr. Wolff's agreement that "what's experimental is whether the therapy is ***better than*** standard alternatives for ovarian cancer." (App. at 17a). (Emphasis added). The Court held that because Dr. Wolff agreed with that statement, he was conceding that the service or supply was "not as safe and effective outside a research setting as" current diagnostic or therapeutic options. However, this interjects a definition of experimental not contained in the Plan. Whether

4. The prejudice to Mrs. Martin was exacerbated by the fact that she did not have notice of the plan terms at the time her request for benefits was being considered. This is because the Plan refused to send **even the Plan language** to Mrs. Martin.

a treatment is "better than" alternatives is a different criteria than whether a treatment is as "safe and effective" as alternatives.

The Court also cited Dr. Wolff's affirmative response to the question of whether or not the procedure was experimental as he defined the term experimental. (App. at 18a). Dr. Wolff's personal definition of "experimental" is not properly considered as to whether the Plan's exclusion has been met; Dr. Wolff's definition is *not* the Plan's definition, which controls. Several Circuit Courts have held that in the context of modern medicine, the term "experimental" seems clearly ambiguous on its face. *Wolf v. Prudential Ins. Co. of America*, 50 F.3d 793, 800 (10th Cir. 1995).

ERISA law makes clear that a decision maker who imposes unwritten policies or requirements beyond the plan is *per se* acting arbitrarily and capriciously. *Wilson v. CHAMPUS*, 65 F.3d 361, 366 (4th Cir. 1995). In *Heasley v. Belden & Blake Corp., supra*, the Third Circuit held that guidelines which are neither referenced nor incorporated into a Plan cannot justify denial. *Id.* at 1261. In *Kekis v. Blue Cross and Blue Shield*, 815 F. Supp. 751, 580 (N.D.N.Y. 1993), it was held that a medical director making or reviewing a benefit decision under an ERISA plan may not rely on his own definition of experimental or one supplied by experts, but *rather is bound to apply the definition found in the Plan.* The Fourth Circuit's decision is contrary to the well established principle set forth in the foregoing cases, specifically, those reviewing benefits denials are bound to apply the definition as written in the Plan. This principle applies to prohibit *courts* reviewing benefit determinations from creating new plan terms.

This Court has previously held, ". . . one of ERISA's central goals is to enable beneficiaries to learn their rights and obligations at any time." *Curtiss-Wright Corp. v. Schoonejongen*,

115 U.S. 1223, 1230 (1995). In addition, this Court has stated the fulfillment of that goal has been accomplished though an elaborate scheme, ". . . a scheme that is built around reliance on the face of written plan documents." *Id.* at 1230. This Court cited several mandatory disclosure requirements, including 29 U.S.C. § 1024(b)(1), and 29 U.S.C. § 1022(a)(1) in concluding that Congress required a written plan "in order that every employee may, *on examining the plan documents*, determine exactly what his rights and obligations are" under the plan. *Curtis-Wright Corp., supra,* at 1230. (Citations omitted) (emphasis added); *See also* 29 U.S.C. § 1102(a)(1). Allowing courts to circumvent the language of the written plan documents undermines ERISA's stated purpose of enabling participants to determine the rights under their plans.

This Court has previously held that a court may not substitute its own judgment for that of the decision maker. *Motor Vehicles Mfrs. Ass'n v. State Farm Mut.*, 463 U.S. 29, 43 (1983). When the decision maker has acted in an arbitrary and capricious manner by relying on factors that it should not have considered, the court may not "supply a reasoned basis for the [decision maker's] action that the [decision maker] itself has not given." *Motor Vehicles*, 463 U.S. at 43; *citing SEC v. Chenrey Corp.*, 332 U.S. 194, 196 (1947). In this case, the Fourth Circuit was not permitted to invoke the "better than" criteria where the only expert testimony in the case established Mrs. Martin's treatment was *not* excluded by the language of the exclusion.

Further support for the fundamental premise that ERISA plan terms cannot be substituted or changed at will by either fiduciaries or courts is found in the long line of cases which hold that any misrepresentation of the Plan terms cannot work to modify the Plan terms. *HealthSouth Rehab. Hosp. v. Amer. Nat'l Red Cross*, 101 F.3d 1005, 1010-11 (4th Cir. 1996); *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54, 58-59 (4th

Cir. 1992), *cert denied*, 506 U.S. 1081 (1993). The Court should not have denied coverage based on criteria and statements that are not part of the written exclusion. Neither the decision maker nor the court can ignore the language of the contract and insert a new exclusion. Such actions will be a "clear error of judgment." *Kulakowski v. Rochester Hosp. Service Corp.*, 779 F. Supp. 711, 717 (W.D.N.Y. 1991) (citation omitted).

In *Firestone*, *supra*, the Court recognized Congress' intent that ERISA provide more protection for participants and beneficiaries that they enjoyed before ERISA's enactment. *Id.* at 112. The Fourth Circuit's opinion in this case erodes that intent in permitting courts to depart from the plan language to deny coverage. Applying the logic of *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402 (1971) and *Motor Vehicle Mfrs. Ass'n*, 463 U.S. 29, 43 (1983), to the instant situation, the Court will prevent the grave injustice which occurs when courts are not bound by the written terms of Plans. This decision as it stands will ultimately encourage litigation for the same reasons discussed in the first question presented above. Here the Fourth Circuit created a new basis for denial not contained in the Plan, the SPD or in any of the denial letters. Rather, the court applied an exclusion not written or otherwise made known to Mrs. Martin until the opinion was issued, three years after the treatment was received. Put simply, there was no way for Mrs. Martin to know of the "better than" criteria the Fourth Circuit relied on in denying coverage. However, had Ms. Martin ever been told of this "better than" criteria, she would not have pursued the litigation if her doctor agreed the medical literature did not support that conclusion. Likewise, if Dr. Wolff's own opinion as to whether the treatment was "experimental" was outcome determinative as to her coverage, she could have simply asked him. However, Mrs. Martin relied on what the Plan said, and several years later was told that a criteria of exclusion not contained in the Plan language prevented payment for her treatment.

CONCLUSION

There are millions of Americans insured through ERISA plans. Based on information obtained from the Administrative Office of the United States Courts, Petitioner discerned that between June of 1996 and June of 1997, over 7,000 ERISA cases were filed in the district courts. Congress and the Judiciary have fashioned a comprehensive scheme in ERISA which functions to give participants and Plans a fair, just and inexpensive means of resolving disputes, while ensuring access to federal courts.

The comprehensive scheme of ERISA did not fail here; it was just never enforced. As a consequence, this carefully crafted scheme has been weakened, fostering more litigation in the federal courts. This Court should grand certiorari to instruct the lower courts on the proper enforcement of 29 U.S.C. § 1133 and to instruct lower courts on how to properly interpret and apply exclusionary language in benefit plans. These instructions will serve to further the purposes of the statute and to fulfill the goal of ensuring that participants who are entitled to benefits actually receive them.

For all reasons stated, Petitioner Ronald Martin, on behalf of the Estate of Nancy Cornelius Martin, deceased, prays that this Court grant a writ of certiorari to review the decision of the United States Court of Appeals for the Fourth Circuit.

Respectfully submitted,

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APPENDIX A — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT FILED AUGUST 8, 1997

UNITED STATES COURT OF APPEALS
FOR THE FOURTH COURT

No. 96-1534

(CA-94-81-C)

Nancy Martin,

Plaintiff - Appellee,

versus

Blue Cross & Blue Shield of Virginia, Inc.,

Defendant - Appellant.

ORDER

The Court amends its opinion filed June 23 1997, as follows:

On page 17, line 28 — the subsequent history for *Boggs v. Boggs* should read "*cert. granted*," 117 S. Ct. 379 (1996).

For the Court — By Direction

/s/ Patricia S. Connor

Clerk

APPENDIX B — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT DECIDED JUNE 23, 1997

PUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 96-1534

B. Waugh Crigler, Magistrate Judge.

(CA-94-81-C)

Argued: April 7, 1997

Decided: June 23, 1997

Nancy Martin,

Plaintiff-Appellee,

v.

Blue Cross & Blue Shield of Virginia, Incorporated,

Defendant-Appellant.

Appeal from the United States District Court for the Western District of Virginia, at Charlottesville.

Before LUTTIG and WILLIAMS, Circuit Judges, and DUFFY, United States District Court Judge for the District of South Carolina sitting by designation.

Appendix B

Reversed by published opinion. Judge Williams wrote the opinion, in which Judge Luttig and Judge Duffy joined.

OPINION

WILLIAMS, Circuit Judge:

In this case, we consider Nancy Cornelius Martin's claim under the Employee Retirement Income Security Act (ERISA), 29 U.S.C.A. § 1001-1461 (West 1985 & Supp. 1997), to obtain insurance benefits for the autologous bone marrow transplant procedure she underwent as treatment for her epithelial ovarian cancer. The magistrate judge[1] concluded that the summary plan description (SPD) issued by Blue Cross & Blue Shield of Virginia (Blue Cross) did not exclude the high-dose chemotherapy and peripheral stem cell rescue elements of Mrs. Martin's procedure and issued a declaratory judgment that Blue Cross must therefore cover those elements of the procedure. Because we conclude that the magistrate judge erred in finding that the procedure was not experimental or investigative, we reverse. We also hold that ERISA permits recovery of attorneys' fees only by prevailing parties, and thus reverse the award of attorneys' fees in favor of Mrs. Martin.

I.

Ronald W. Martin, Mrs. Martin's husband, was one of the owners of a business known as Ray Fisher and Ron Martin, Incorporated (The Company). During its twenty-eight years of operations, the Company maintained a welfare benefit plan for

1. The parties consented to submission of the case to a magistrate judge's dispositive jurisdiction under 28 U.S.C.A. § 636(C) (West 1993 & Supp. 1997).

its employees. Mrs. Martin, as Mr. Martin's wife, was a beneficiary of the health insurance coverage established and maintained by the Company. On behalf of the Company, Mr. Martin often changed health insurance policies to minimize costs, although in recent years he changed policies less often. In October 1993, Mr. Martin contracted with Blue Cross to provide the Company's health insurance and to administer the plan. Mrs. Martin claims that although the Company received copies of the SPD, Blue Cross never provided the Company with a copy of the insurance contract itself (the Plan).

Around this same time, Mrs. Martin was diagnosed with epithelial ovarian cancer. In 1994, Mrs. Martin was referred to Dr. Steven Wolff, an oncologist at Vanderbilt University Medical Center (Vanderbilt). Dr. Wolff recommended that to treat her ovarian cancer, Mrs. Martin undergo a regimen of high-dose chemotherapy coupled with stem cell rescue and autologous bone marrow transplant. The parties do not dispute that the procedure at issue consists of three phases. The first of these, stem cell rescue, involves the harvesting of the patient's bone marrow cells.[2] Then, while the harvested cells are frozen and

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2. There are at least two methods of stem cell rescue. The stem cells may be extracted from the bone marrow itself in a procedure called autologous bone marrow harvest. In such a procedure, "the rear hip bones, are aspirated of their marrow by long needles done percutaneously through the skin." J.A. at 597.) The stem cells may also be extracted from the blood itself in a procedure called peripheral stem cell rescue. In such a procedure, the stem cells are mobilized from their normal residence and collected by a process called leukapheresis. The difference is of no consequence to the resolution of this case. As explained by Dr. Wolff. Mrs. Martin's treating physician and expert witness, "It's not probably crucial where those cells come from. Those cells should be viewed not therapeutically, but should be viewed as supportive care for the patient

(Cont'd)

stored, the second stage — high-dose chemotherapy — is conducted. The dosage is so strong that the patient's remaining bone marrow cells are destroyed or damaged so severely that they grow back slowly. The third stage involves the reinfusion of the harvested cells into the patient. This reinfusion is necessary to save the patient's immune system, which would otherwise be crippled by the damage to the bone marrow cells during the high-dose chemotherapy stage. Dr. Wolff, Mrs. Martin's treating physician and expert witness, described the entire procedure as "the administration of cytotoxic therapy of such magnitude that the bone marrow, the organ of the body that makes all the blood cells, is substantially injured necessitating the administration or transfusion of additional bone marrow cells to aid in the recovery of bone marrow function induced by the damage of the chemotherapy or radiation therapy." (J.A. at 595.) There is evidence in the record that the term "autologous bone marrow transplant" is often used to describe not only the third stage of the process, but also the entire procedure, including stem cell rescue and high-dose chemotherapy.

Dr. Wolff testified that, at the time of Mrs. Martin's treatment, fewer than five women had ever undergone the same procedure for epithelial ovarian cancer. In fact, the procedure was classified as a Phase II clinical trial. Such clinical trials are regulated by the Food and Drug Administration and the Department of Health and Human Services and require a

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undergoing that type of therapy." (J.A. at 595) Moreover, the difference in terminology is sometimes ignored. "They are different procedures but the casual term, [autologous bone marrow transplant], can sometimes denote either one of those sources of bone marrow — of bone marrow stem cells." (J.A. at 599.)

protocol document to standardize the procedure. As explained by Dr. Wolff, a protocol explains "what you're doing, why you're doing [it], the rationale, who is eligible for this type to therapy, what the therapy is, how to administer the therapy, how to care for the patients, what the complications of expected nature are and how you could analyze the information that you get." (J.A. at 605.) Such clinical trials also require that each participating patient be advised of the nature of the treatment and its attendant risks.

On April 27, 1994, Dr. Wolff requested pre-authorization from Blue Cross, specifically indicating that he was "requesting authorization for the treatment of this patient with high-dose chemotherapy with autologous stem cell and marrow rescue." (J.A. at 17.) Soon thereafter, on April 29, 1994, Blue Cross denied pre-authorization. The offered reason for the denial was that "[h]igh-dose chemo(radio)therapy is considered investigational in the treatment of epithelial ovarian cancer." (J.A. at 18.) On June 6, 1994, Dr. Wolff again wrote to Blue Cross, appealing its initial coverage decision. On June 9, 1994, Blue Cross reaffirmed its denial of coverage, stating that it "must deny proposed high-dose chemotherapy for diagnosis epithelial ovarian carcinoma from two viewpoints: a) policy denial — considered investigational in diagnosis of epithelial ovarian cancer [and] b) contractually excluded per amendment to group policy — not covered for ovarian cancer other that germ cell tumors." (J.A. at 20.) Mrs. Martin's final appeal to Blue Cross was by a letter from her lawyer on July 6, 1994, which included several medical articles on the effectiveness of the recommended treatment for ovarian cancer. Blue Cross responded on August 2, 1994, explaining that

> [t]he Technology Evaluation and Coverage (TEC)

> program of the Medical Advisory panel of the Blue Cross and Blue Shield Association reviewed all of the scientific published peer reviewed literature on [autologous bone marrow transplant] for treating epithelial ovarian cancer. The treatment modality does not meet our coverage eligibility guidelines. I have enclosed a copy of these guidelines for you.

(J.A. at 1014.) Blue Cross appended to this letter its five-factor analysis for determining if a procedure was experimental or investigative.

In July of 1994, before receiving the final letter from Blue Cross but after receiving both denials of pre-authorization, Mrs. Martin decided to undergo the procedure. Mrs. Martin conceded that she "actually underwent the procedure . . . with knowledge that Blue Cross was taking the position it wasn't covered." (J.A. at 297.) The procedure was successful, and she was discharged from the hospital in August of 1994.

On November 28, 1994, Mrs. Martin filed this action against Blue Cross in the United State District Court for the Western District of Virginia. She brought the suit under 29 U.S.C.A. 1132(a)(1)(B) (West 1985), as a beneficiary of an employee welfare benefit plan. From the beginning of the lawsuit, Mrs. Martin maintained that the Company never received a copy of the Plan and therefore that the SPD controlled. The magistrate judge bifurcated the trial to determine, first, which document — the Plan or the SPD — controlled the analysis and second, whether under the controlling document, Mrs. Martin's treatment was excluded.

On July 5, 1995, the magistrate judge held a hearing on the

first issue and ruled from the bench that the Company never received a copy of the Plan. He therefore concluded that the SPD controlled. Later, on December 13, 1995, the magistrate judge held a second evidentiary hearing to determine if Mrs. Martin's treatment was covered. In a memorandum opinion issued on January 22, 1996, the magistrate judge reaffirmed his earlier ruling from the bench that the procedure was not experimental or investigative within the meaning of the SPD's exclusion. He further concluded that an exclusion for "autologous bone marrow transplants" in the SPD did not exclude the related services of high-dose chemotherapy and stem cell rescue. Therefore, the magistrate judge entered a declaratory judgment of coverage for those two phases of the procedure.

Thereafter, Mrs. Martin petitioned the court for attorneys' fees. The magistrate judge granted the motion and, in an order of final judgment entered on March 13, 1996, awarded attorneys' fees. Blue Cross appeals, claiming that the entire procedure was excluded under the Plan's and the SPD's exclusion for experimental or investigative procedures, as well as under the exclusions in the Plan and the SPD for autologous bone marrow transplants. Blue Cross also challenges the award of attorneys' fees in favor of Mrs. Martin. We conclude that under the terms of the Plan and the SPD, the procedure was experimental or investigative and that Mrs. Martin is not entitled to insurance coverage for any phase of the procedure or to attorneys' fees. Accordingly, we reverse.

II.

Blue Cross claims that the magistrate judge erred in concluding that the procedure at issue was not experimental or investigative within the meaning of the Plan's and the SPD's

exclusion. The magistrate judge assumed that, because "the SPD controls this case" (J.A. at 748), review of Blue Cross's denial of benefits was de novo. We disagree with the magistrate judge's assumption that the SPD controls the case and with the magistrate judge's application of a de novo standard of review. We will assume without deciding that the Plan itself was never received by the Company — a point the parties argue at considerable length — because, in our view, the receipt or nonreceipt of the Plan is irrelevant. In the Fourth Circuit, "if there [is] a conflict between the complexities of the plan's language and the simple language of the [SPD], the latter [will] control if the participant relied on the SPD or was prejudiced by it." *Hendricks v. Central Reserve Life Ins. Co.*, 39 F.3d 507, 511 (4th Cir. 1994) (quotation omitted).

Mrs. Martin fails at the first step. The SPD provided "a brief list of exclusions that apply to [the] program." (J.A. at 837-38.) This "brief list" specifically stated that "Comprehensive Major Medical benefits will not be provided for the following: . . . Experimental or investigative procedures. . . ." (J.A. at 837-38.) The Plan itself excludes "[a]ny service determined to be Experimental/Investigative by the Company, in its sole discretion." (J.A. at 900.) The Plan further explains that the phrase

> Experimental/Investigative . . . describes any service or supply which is judged to be experimental or investigative by the Company in its sole discretion. The Company will use the following criteria to decide this:
>
> 1. any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration;

> 2. there must be enough information in the peer reviewed medical and scientific literature to let the Company judge the safety and efficacy;
>
> 3. the available scientific evidence must show a good effect on health outcomes outside a research setting; and
>
> 4. the service or supply must be as safe and effective outside a research setting as current diagnostic or therapeutic options.
>
> A service or supply will be experimental or investigative if the Company decides that any one of the our criteria is not met.

(J.A. at 885.)[3] Therefore, because the Plan gives more detail than the SPD but does not contradict its terms, there is no conflict between the Plan and the SPD.

Circuit precedent supports this conclusion. In *Hendricks*, we considered an argument that "the district court, in ruling on coverage for his treatment, improperly relied upon definitions of the terms 'experimental' and 'investigative' in the official plan document maintained in Central Reserve's files and did not rest its decision on the terms of the summary plan description circulated to employees." 39 F.3d at 511. There, as here, the summary plan description used only the words "experimental or investigative," while the plan defined the exclusion in greater detail. After carefully reviewing the common understanding of the terms "experimental or investigative," we upheld the view

3. These four factors are very similar to the five factors appended to Blue Cross's letter of August 2, 1994, denying coverage.

of "the district court that the definitions of 'experimental' and 'investigative' given in the official plan document are not so different from common understandings of the terms that they can be thought to conflict with those understanding." *Id.* at 512. We think that the reasoning of *Hendricks* is equally applicable here. Because the additional considerations outlined in the Plan " are not so different from the common understandings of the terms," no conflict exists between the SPD and the Plan. As noted in *Hendricks*, when "the summary plan description and the plan itself do not conflict, our cases provide no prohibition against review of the official plan itself for a fuller understanding of the plan's terms. Indeed, in those circumstances the plan is the controlling document for determining the scope of benefits provided." *Id.*

We also find that no conflict arises from the Plan's grant of discretion to Blue Cross to determine whether a procedure is experimental or investigative. Although the SPD contains no such language, we find no conflict between the absence of discretionary language in the SPD and its presence in the Plan. Vesting the plan administrator with discretion in making coverage decisions simply does not conflict with the SPD's silence on the matter.[4] *See Atwood v. Newmont Gold Co.*, 45

4. Moreover, even were we to conclude that the Plan's grant of discretionary authority conflicted with the SPD's silence, Mrs. Martin could hardly argue that she relied on or was prejudiced by the SPD's failure to describe the appropriate standard for coverage decisions. As explained by the Ninth Circuit, "The language of the SPD in this case amply informed [the beneficiary] that there was a danger that he would be ineligible for severance benefits if he resigned. The omission of plan language placing the determination in the discretion of [the employer] does not undermine this conclusion." *Atwood v. Newmont Gold Co.*, 45 F.3d 1317. 1321 (9th Cir. 1995). Here, Mrs. Martin knew that the Blue

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F.3d 1317, 1321 (9th Cir. 1995) (holding that even though the summary plan description did not include discretionary language, the grant of discretionary authority in the plan controlled); *see also Jensen v. SIPCO, Inc.*, 38 F.3d 945, 952 (8th Cir. 1994) (explaining that the plan will control "when the plan document is specific and the SPD is silent on a particular matter"). Therefore, the Plan controls, and it vests the administrator of the plan with discretion in making coverage decisions.

Because the magistrate judge erred in finding a conflict between the SPD and the Plan and in concluding that the SPD controlled, he also erred in choosing the standard under which to review Blue Cross's denial of benefits. In actions under ERISA challenging the denial of benefits, we apply the standard of review described in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). Under this standard, we must show deference to the denial of benefits by an administrator with discretionary powers to determine eligibility for benefits, and we will reverse the administrator's denial of benefits only upon a showing of abuse of discretion. *See id.* at 115; *Doe v. Group Hosp. & Med. Servs.*, 3 F.3d 80, 85 (4th Cir. 1993). This standard is slightly modified, however, when the administrator labors under a conflict of interest. In our Circuit,

> when a fiduciary exercises discretion in interpreting a disputed term of the contract where one interpretation will further the financial interests of the fiduciary, we

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(Cont'd)
Cross policy did not cover experimental or investigative procedures, and she cannot claim to have been prejudiced by the fact that she did not know how Blue Cross would determine whether, applied to her illness, the procedure was experimental or investigative.

> will not act as deferentially as would otherwise be appropriate. Rather, we will review the merits of the interpretation to determine whether it is consistent with an exercise of discretion by a fiduciary acting free of the interest that conflict with those of the beneficiaries.
>
> In short, the fiduciary decision will be entitled to some deference, but this deference will be lessened to the degree necessary to neutralize any untoward influence resulting from the conflict.

Doe, 3 F.3d at 87; *see also Bedrick v. Travelers Ins. Co.*, 93 F.3d 149, 152 (4th Cir. 1996) ("Inasmuch as the law is highly suspect of 'fiduciaries' having a personal interest in the subject of their trust, the 'abuse of discretion' standard is not applied in as deferential a manner to" plans where "the insurer processes and pays claims *and* acts as plan administrator."). Therefore, the appropriate standard under which to review Blue Cross's denial of benefits to Mrs. Martin is not de novo, as used by the magistrate judge, but rather a modified abuse of discretion standard.

In light of the magistrate judge's application of the wrong standard in reviewing Blue Cross's denial of benefits, remand would ordinarily be appropriate. In our view, however, remand is unnecessary because we conclude, as a matter of law, that the procedure at issue was experimental or investigative within the meaning of the Plan.

We first note that we have twice considered the issue, in different contexts. In *Hendricks*, 39 F.3d at 509, we considered the identical procedure as administered to a patient with small

cell lung cancer. The procedure at issue in *Hendricks* was a clinical trial, regulated by the Food and Drug Administration and the Department of Health and Human Services. Furthermore, Hendricks signed an informed consent form and was subject to a protocol. Finally, Hendricks was one of the first patients to undergo high-dose chemotherapy with stem cell rescue for his particular type of cancer. We concluded that although,

> the components of the treatment proposed are fairly well known and data demonstrate that high-dose chemotherapy generally has a tendency to improve a patient's responses to cancer, the date failed to demonstrate that small cell lung cancer would be more effectively treated with high-dose chemotherapy than with standard chemotherapy.

Id. at 514. Later, however, in *Wilson v. CHAMPUS*, 65 F.3d 361 (4th Cir. 1995), a case that did not cite *Hendricks*, we held that autologous bone marrow transplant with high-dose chemotherapy was not experimental or investigative when administered for breast cancer. We rejected the argument that "published, Phase III clinical trial results are required before a benefit can be provided." *Id.* at 365. Instead, we reasoned that "there is considerable evidence that Phase III clinical trials are not the critical aspect in determining whether a therapy has become 'generally accepted' within the medical community." *Id.* This reasoning, coupled with our review of the medical literature, held us to conclude that high-dose chemotherapy with stem cell rescue was not experimental or investigative when used to treat breast cancer.

Hendricks and *Wilson* make clear that an insurance policy

may limit coverage depending on the type of cancer involved. Although both cases involved the same procedure, we reached different results for small cell lung cancer and for breast cancer. Here, we concluded that, at the time Mrs. Martin underwent the procedure, Blue Cross did not abuse its discretion in determining that autologous bone marrow transplant with high-dose chemotherapy for epithelial ovarian cancer was experimental or investigative.

Blue Cross extensively reviewed the medical literature before denying Mrs. Martin's application for coverage. In April of 1994, the National Institutes of Health (NIH) produced a consensus statement on "Ovarian Cancer: Screening, Treatment, and Followup." (J.A. at 1035.) The statement specifically noted that "high-dose chemotherapy with hematopoietic growth factors or bone marrow transplantation is experimental, and its use should be limited to research settings." (J.A. at 1046.) Dr. John L. Colley, Blue Cross's expert witness, testified that when the coverage decision for Mrs. Martin was made, Blue Cross "had seen the NIH statement." (J.A. at 568.) Further, as explained by Dr. Colley, "[t]he independent, seventy (70) or so Blue [Cross/Blue Shield] plans across the country [formed an] association [that] has a technology assessment program [the Technology Evaluation Center] that looks at emerging technologies and . . . they have a . . . very elaborate evaluation process for literature review and attendance at scientific meetings. . . ." (J.A. at 560.) In 1994, the Technology Evaluation Center produced an eighteen-page assessment that "review[ed] the available evidence to determine whether high-dose chemotherapy with autologous stem cell support (HDC/AuSCS) improves survival for patients with epithelial ovarian cell cancer." (J.A. at 1056.) The assessment "focuse[d] on evidence published since 1990, briefly review[ed] the earlier evidence, and synthesiz[ed] the

prior conclusions with the new evidence." (J.A. at 1056.) After an extensive review of the available literature in the eighteen-page report, the Technology Evaluation Center concluded that "high-dose chemotherapy with autologous stem cell support for the treat of epithelial ovarian cancer does not meet the Blue Cross and Blue Shield Association Technology Evaluation Center (TEC) criteria." (J.A. at 1074.) Dr. Colley testified that Blue Cross relied on this assessment in denying coverage for Mrs. Martin's procedure, and Blue Cross specifically mentioned the assessment in its final denial of coverage to Mrs. Martin. Dr. Colley also testified that, when Mrs. Martin's application for coverage was denied, nothing had "come to Blue Cross'[s] attention to cast doubt on the original understanding that [high-dose chemotherapy with autologous bone marrow transplant] was experimental [or] investigative for ovarian cancer." (J.A. at 568.) In fact, there is no testimony in the record that this treatment has yet become generally accepted or standard practice for treatment of epithelial ovarian cancer.

Our conclusion that Blue Cross conducted an adequate review of the medical evidence and did not abuse its discretion in denying benefits is sufficient to dispose of Mrs. Martin's claim. But because the magistrate judge considered evidence beyond that which was before the administrator,[5] and because

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5. In *Sheppard & Enoch Pratt Hosp. v. Travelers Ins. Co.*, 32 F.3d 120. 125 (4th Cir. 1994), we reaffirmed our view that, when the administrator is vested with discretion in making coverage decisions, "an assessment of the reasonableness of the administrator's decision must be based on the facts known to it at the time." *See also Berry v. Ciba-Geigy*, 761 F.2d 1003 (4th Cir. 1985) (same. pre-*Firestone*). On the other hand, we have held that in conducting de novo review of an administrator's coverage decision, the reviewing court may consider evidence that was not before the administrator "only when circumstance clearly establish

(Cont'd)

neither party objected to the consideration of such evidence, we note that the extrinsic evidence presented at the hearing does not undermine Blue Cross's denial of coverage.

The Plan requires that, to avoid exclusion as experimental or investigative, the procedure meet four criteria, one of which is that it "be as safe and effective outside a research setting as current diagnostic or therapeutic options." *See supra* p.11. Likewise, one of the five factors included in Blue Cross's final denial of coverage was that "[t]he available scientific evidence must demonstrate a net beneficial effect on health outcomes." (J.A. at 25.) Dr. Wolff, Mrs. Martin's own expert witness, agreed with the statement that "what's experimental is whether the therapy is better than standard alternatives for ovarian cancer." (J.A. at 489.) Therefore, although Dr. Wolff testified that application of Blue Cross's coverage factors otherwise indicated that the procedure was not experimental or investigative, and although his testimony was credited by the magistrate judge, he conceded that at least one of the factors precluded coverage because there was a lack of evidence to prove that this procedure was "as safe . . . as current diagnostic or therapeutic options." The Plan makes clear that coverage will be denied if "any one of the four criteria" indicated that the procedure is experimental or investigative, and Dr. Wolff's concession cannot support Mrs. Martin's claim for benefits.

Moreover, Dr. Wolff answered affirmatively when asked

(Cont'd)
that additional evidence is necessary to conduct an adequate *de novo* review of the benefit decision." *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017. 1025 (4th Cir. 1993) (en banc). Here, the magistrate judge incorrectly assumed that review of Blue Cross's coverage denial was de novo and therefore considered evidence that was not before the administrator.

whether "high-dose chemotherapy with autologous bone marrow transplant for ovarian cancer patients is experimental as you define the term experimental." (J.A. at 687.) Therefore, Dr. Wolff himself testified that, in the general sense of the term, Mrs. Martin's procedure was experimental or investigative. In other words, not only did Mrs. Martin's expert testify that at least on coverage factor indicated that the procedure was experimental or investigative, he also testified that he himself considered the procedure experimental or investigative.

Finally, Mrs. Martin's procedure, like that in *Hendricks*, was part of a clinical trial, more specifically a Phase II clinical trial.[6] In this regard, the magistrate judge clearly erred in concluding that "what was considered a clinical trial in November 1993 on the evidence before the district judge in *Hendricks*, was not a clinical trial according to the preponderance of the evidence in this case." (J.A. at 771.) In fact, it is uncontradicted in the record that Mrs. Martin's procedure was part of a Phase II clinical trial. In his deposition, Dr. Wolff explained that "a Phase [II] study really tries to answer the question in a specific disease situation how effective is the therapy intervention that you're trying. You have to also note that to do in phase [II] studies means you're not taking standard therapy. . . ." (J.A. at 496.) Although *Wilson* specifically rejected the argument that lack of a Phase III clinical trial renders a procedure experimental or investigative, Mrs. Martin's participation in a Phase II clinical trial strongly supports Blue Cross's conclusion that the procedure, when administered to

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6. As we have previously explained, "Phase III is the final stage of medical clinical trials. In Phase I, a new therapy is given to human beings for the first time. . . . In Phase II, the treatment is given to a larger group to determine whether the procedure is effective in treating a disease." *Wilson v. CHAMPUS*. 65 F.3d 361 n.5 (4th Cir. 1995).

Mrs. Martin, was experimental or investigative. Moreover, the required protocol for Mrs. Martin's procedure stated, "THIS STUDY IS ENTIRELY RESEARCH." and "THIS STUDY IS AN INVESTIGATIONAL TREATMENT PROGRAM." (J.A. at 939.) Finally, Mrs. Martin signed an informed consent form before undergoing the procedure. In this consent form, it was noted that:

> Both of these drugs are used in standard therapy for various tumors either separately or in combination. Recently, there is some evidence that each of these agents may be more effective if given at doses much greater than normal. The use of the higher doses and the combination of these drugs at the higher doses is the investigational (research) part of this study. *The combination of these drugs in high-doses have been used in only a few patients. Preliminary observations suggest that this therapy may be effective. It is the purpose of this study to determine the effectiveness and safety (side effects) of this high-dose therapy. It must be understood that compared to standard therapy the use of the therapy in this study will produce more serious side-effects and should be considered substantially more risky.*

(J.A. at 951 (emphasis added).) Therefore, Mrs. Martin knew before undergoing the procedure that it was considered experimental or investigative.

In short, Blue Cross did not abuse its discretion in denying benefits to Mrs. Martin because its decision was based on an extensive review of the available literature. Moreover, the extrinsic evidence considered by the magistrate judge support

Blue Cross's denial of coverage. Dr. Wolff testified that at least one of Blue Cross's coverage factors indicated that the procedure was experimental or investigative and that he himself considered the procedure experimental or investigative. In addition, Mrs. Martin herself knew that the procedure was experimental or investigative because it was part of a Phase II clinical trial, was subject to a protocol, and required Mrs. Martin's informed consent. In light of this evidence, we cannot say that Blue Cross abused its discretion, even the more limited discretion afforded to a fiduciary acting under a possible conflict of interest, in concluding that the procedure here was experimental or investigative when used to treat epithelial ovarian cancer.

Finally, we note that we are not at liberty to "fragment" the procedure into its component parts under the exclusion for experimental or investigative procedures. In *Hendricks*, we concluded that "[t]o fragment the phases of treatment and consider each in light of the policy language produces an unrealistic and distorted analysis." 39 F.3d at 514. In doing so, we distinguished *Doe v. Group Hosp. & Med. Servs.*, 3 F.3d 80 (4th Cir. 1993), which held that fragmentation of the treatment was permissible under an exclusion for autologous bone marrow transplants. In *Hendricks*, we reasoned that because "the treatment which is experimental or investigative includes the high-dose chemotherapy as well as the preparational and recovery phases of treatment, the scope of the exclusion here is broader" than the scope of the autologous bone marrow transplant exclusion considered in *Doe*. 39 F.3d at 515. Applying *Hendricks*, we hold that Mrs. Martin cannot recover the cost of any part of the procedure.[7]

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7. In light of our disposition of this issue, we need not decide whether reimbursement for the procedure was also prevented by the exclusion of autologous bone marrow transplants contained in both the Plan and the SPD.

Appendix B

III.

The magistrate judge also awarded attorneys' fees to Mrs. Martin. We review the award of attorneys' fees under ERISA for abuse of discretion. *See Densler v. Questech, Inc.*, 80 F.3d 97, 103 (4th Cir. 1996). Here, the magistrate judge abused his discretion by basing the award of attorneys' fees on a faulty legal standard. The magistrate judge stated that attorneys' fees "under ERISA[ ] should be recovered by the prevailing party absent special circumstance rendering the award unjust." (J.A. at 795.) We have specifically rejected such a standard, holding that "there [is] no presumption in favor of awarding attorney's fees to a prevailing insured or beneficiary." *Denzler*, 80 F.3d at 104. Therefore, the magistrate judge erred in applying a presumption that attorneys' fees should be recovered by a prevailing ERISA claimant.

Although we would ordinarily remand for an application of the correct legal principles, remand here is unnecessary because Mrs. Martin is not entitled to attorneys' fees as a matter of law. We have held that, in awarding attorneys' fees, we consider five factors:

(1) degree of opposing parties' culpability or bad faith;

(2) ability of opposing parties to satisfy an award of attorney's fees;

(3) whether an award of attorney's fees against the opposing parties would deter other persons acting under similar circumstances;

(4) whether the parties requesting attorney's fees sought

> to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and
>
> (5) the relative merits of the parties' positions.

Id. at 104. Although we have never specifically held that only prevailing parties are entitled to attorneys' fees under ERISA, we have often indicated that reversal of a judgment under ERISA also requires reversal of any attendant award of attorneys' fees. *See, e.g., Freeman v. Central States, Southeast & Southwest Areas Pension Fund*, 32 F.3d 90, 94 (4th Cir. 1994) (explaining that, because the district court clearly erred in its ruling, "[t]he judgment, as well as the derivative award of attorney's fees and costs, must therefore be reversed"); *Elmore v. Cone Mills Corp.*, 23 F.3d 855, 863 (4th Cir. 1994) (en banc) (explaining, in a action under ERISA, that "[o]ur reversal of the prior judgment also requires that we vacate the award of attorneys' fees to Plaintiffs"); *Fuller v. FMC Corp.*, 4 F.3d 255. 264 (4th Cir. 1993) (reversing a judgment under ERISA and holding that "[b]ecause of our rulings in favor of [the employer], we must also reverse the award in favor of [plaintiffs] for attorney's fees"). We have also suggested, without explicitly holding, that only prevailing parties are entitled to be considered for an award of attorneys' fees under ERISA. *See Custer v. Pan American Life ins. Co.*, 12 F.3d 410, 423 (4th Cir. 1993) (stating that a plaintiff under ERISA "must demonstrate more than merely being the prevailing party on a single issue to demand entitlement to attorneys' fees"). Moreover, many of our sister circuits have imposed a "prevailing party" limitation on the availability of attorneys' fees under ERISA. *See Cottrill v. Sparrow, Johnson & Ursillo, Inc.*, 100 F.3d 220. 225 (1st Cir. 1996) (considering "the degree of culpability or bad faith attributable to the *losing* party" and "the

depth of the *losing* party's pocket" (emphasis added)); *Boggs v. Boggs*, 82 F.3d 90, 94 n.1 (5th Cir.) (explaining that ERISA "allows the court to award ERISA beneficiaries, participants, and fiduciaries reasonable attorney's fees and costs when they are the prevailing party"), *cert. denied*, 117 S. Ct. 379 (1996); *Little v. Cox's Supermarkets*, 71 F.3d 637, 644 (7th Cir. 1995) (asking the bottom-line question" of whether "the *losing* party's position [was] substantially justified and taken in good faith" (emphasis added)); *Eddy v. Colonial Life Ins. Co.*, 59 F.3d 201. 206 (D.C. Cir. 1995) (considering the "*losing* party's culpability or bad faith" and "the losing party's ability to satisfy a fee award" (emphasis added)); *McPherson v. Employees' Pension Plan*, 33 F.3d 253, 254 (3d Cir. 1994) (noting that "[a]ttorneys' fees may be awarded to prevailing parties in actions brought under" ERISA); *see also Flanagan v. Island Empire Elec. Workers Pension Plan & Trust*, 3 F.3d 1246, 1253 (9th Cir. 1993) (admitting that it had "said in dictum that [the ERISA fee provision] permits an award of fees to a non-prevailing party," but holding that "plaintiffs cannot recover fees under section 1132(g)(1) until they succeed on any significant issue in litigation which achieves some of the benefit [they] sought in bringing suit" (quotations omitted and alterations in original)). *But cf. Miller v. United Welfare Fund*, 72 F.3d 1066, 1074 (2d Cir. 1995) (stating that ERISA "contains no requirement that the party awarded attorneys' fees be the prevailing party"). Because of the strong suggestions in our own precedent, supported by the weight of authority from other circuits, we now make clear that in the Fourth Circuit, only a prevailing party is entitled to consideration for attorneys' fees in an ERISA action. We have denied Mrs. Martin's claim in full, and therefore she is not entitled to attorneys' fees. Accordingly, we reverse the magistrate judge's award of attorneys' fees.

Appendix B

IV.

We hold that the magistrate judge erred in concluding that Mrs. Martin's procedure was not experimental or investigative. Because circuit precedent precludes fragmentation of the autologous bone marrow transplant procedure for purposes of the experimental or investigative exclusion, we deny Mrs. Martin's claim in full, including claim for attorneys' fees.

REVERSED

APPENDIX C — MEMORANDUM OPINION AND ORDERS OF THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF VIRGINIA, CHARLOTTESVILLE DIVISION DATED MARCH 13, 1996

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
CHARLOTTESVILLE DIVISION

CIVIL ACTION

NUMBER 94-0081-C

By: B. Waugh Crigler
U.S. Magistrate Judge

NANCY MARTIN,

Plaintiff,

v.

BLUE CROSS AND BLUE SHIELD OF VIRGINIA,

Defendant.

MEMORANDUM OPINION

This action is before the court on plaintiff's February 2, 1996 motion for attorney's fees and costs under 29 U.S.C. § 1132(g)(1). Aside from opposing the fees and costs on the basis that plaintiff was not entitled to judgment in the first instance, defendant's substantive opposition is narrow. It does not contest either the hourly rate or the number of hours spent by plaintiff's counsel. It asks only that the court reduce the award because there is no evidence that it acted in bad faith when it

took the position that the procedures undertaken were excluded from coverage.

While the statute itself provides simply for the recovery of "reasonable attorney's fees and costs," decisional authority requires that the court consider five factors in determining an ERISA fee award. Those factors are:

(1) The degree of the opposing party's culpability or bad faith;

(2) the ability of the opposing party to satisfy an award;

(3) Whether an award would deter other persons acting under similar circumstances;

(4) whether party requesting fees sought to benefit all participants and beneficiaries or to resolve a significant legal question under ERISA;

(5) the relative merits of the parties' positions. *See Wheeler v. Dynamic Engineering, Inc.*, 62 F.3d 634 (4th Cir. 1995); *Reinking v. Philadelphia American Life Ins. Co.*, 910 F.2d 1210 (4th Cir. 1990).

Defendant does not quarrel with counsel's qualifications and, with one minor exception, it does not challenge the hourly rate or the number of hours spent on the case. Defendant, however, does ask that the overall request be reduced because it believes it acted in good faith throughout this case.

The minor quarrel addresses a charge of $9.50 for securing a copy of a consent form from Vaderbilt Hospital that was never produced in discovery but which showed that even the hospital

considered plaintiff's treatment to be investigational. In this court's view Blue Cross has spent more time and expense challenging this April 17, 1995 charge than it would have cost paying it, though its point about the substantive importance of the document has not been lost on the court. While it will not avail a change in the court's mind on the merits of the case, the court will deduct $9.50 from counsel's claim for fees.

The major point defendant makes relates to whether the overall claim for fees should be reduced substantially because there has been no showing that Blue Cross acted in bad faith. As the court sees it, the question of culpability or bad faith is but a factor to consider. Whether such exists, however, is not the *sine qua non* of a fee award. To put it another, way, the statute does not make an award of a reasonable fee dependent upon whether the losing party was culpable, that such may be considered in determining the overall reasonableness of action taken by the opposing party's counsel in pursuing a particular matter. As *Wheeler* infers, and as the court in *Werner v. Upjohn Co.*, 628 F.2d 848 (4th Cir. 1980) clearly revealed, culpability goes beyond simple inadvertence or mistake and involves culpable conduct such as breach of a legal duty. Accordingly, fees incurred pursuing matters clouded by culpable, censurable conduct may very well be revealed as more reasonable when challenged than if the same fee is claimed without such culpable conduct on the part of the opposing party.

In this case, however, we have what the court can best describe as an old fashion dog fight over both legal and factual issues. It is one in which no quarter has been drawn. Defendant has insisted throughout that the procedures employed to treat plaintiff were excluded under both the SPD and the Plan. Plaintiff suggests that defendant had litigated and lost a similar issue in *Doe v. Group Hospital*, 3 F.3d 80 (4th Cir. 1993), and that Doe

was its "first bite." Denials thereafter on the same grounds assert in *Doe*, according to plaintiff's view of the case, would be culpable.

What this court believes defendant misses in its attempts to reduce the fee award because of its alleged lack of culpability is that the five-factor test is but a guide to aid the courts in arriving at a fee which, under ERISA, should be recovered by the prevailing party absent special circumstances rendering the award unjust. *Reinking v. Philadelphia American Life Ins. Co.* 910 F.2d 1210, 1218 (4th Cir. 1990). This skirmish over defendant's culpability has no bearing on whether plaintiff receives the amount sought. It amounts to little more than a loosing party suggesting "Give me a break." Candidly, defendant's position would have had more credibility with the court had it been put that way from the beginning.

Here, defendant does not challenge the reasonableness of the time spent by plaintiff's counsel except for the $9.50 item addressed above. If the five-factor test is a litmus test, plaintiff would prevail, by concession, on four out of the five elements. Since it is not a test, only a guide, four out of five, in this court's view, "ain't bad." An order will enter granting plaintiff's motion for fees and costs and award the sum of $56,640.90 in attorney's fees ($56,650.40 less $9.50) and $2,817.47 in costs.

The Clerk of the Court is hereby directed to send a certified copy of this Memorandum Opinion to all counsel of record.

ENTERED: _____

United States Magistrate Judge

_____

Date

Appendix C

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
CHARLOTTESVILLE DIVISION

CIVIL ACTION

NUMBER 94-0081-C

By: B. Waugh Crigler
U.S. Magistrate Judge

NANCY MARTIN,

Plaintiff,

v.

BLUE CROSS AND BLUE SHIELD OF VIRGINIA,

Defendant.

ORDER

Having reviewed the latest decision by the Fourth Circuit in *Stiltner v. Barette USA Corp.*, __ F.2d __, 1996 WL 42225 (4th Cir., February 2, 1996) and believing: (1) that the result reached in this case is not inconsistent therewith because plaintiff clearly was prejudiced by the coverage representations in the instant SPD, and (2) that the court's prior determination on January 22, 1996 is supported by the facts and law, it is

ORDERED

that defendant's February 16, 1996 motion to reconsider and its

Appendix C

February 20, 1996 renewed motion to reconsider be, and same hereby are denied.[1]

The Clerk of the Court is hereby directed to send a certified copy of this Order to all counsel of record.

ENTERED: _____

United States Magistrate Judge

_____

Date

1. The February 20, 1996 motion renews defendant's motion to reconsider filed on September 20, 1995 which should now be removed from the pending motions docket.

Appendix C

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
CHARLOTTESVILLE DIVISION

CIVIL ACTION

NUMBER 94-0081-C

By: B. Waugh Crigler
U.S. Magistrate Judge

NANCY MARTIN.

Plaintiff,

v.

BLUE CROSS AND BLUE SHIELD OF VIRGINIA,

Defendant.

ORDER

For the reasons set forth from the bench on July 5, 1995 and on December 13, 1995 and for the reasons contained in this court's Memorandum Opinion of even date, it is

ORDERED

that plaintiff, Nancy Martin, have and recover judgment against the defendant Blue Cross and Blue Shield of Virginia, and the court hereby DECLARES as follows:

1) Ray Fischer and Ron Martin, Inc. ("Martin, Inc.") never received the Blue Cross Comprehensive Insurance Policy; and

2) The Summary Plan Description ("SPD") language governs a determination of coverage of the procedures which are the subject of this action; and

3) The SPD did exclude from coverage the costs for the autologous bone marrow transplant procedure employed as part of plaintiff's overall treatment; but that

4) The SPD did not exclude from coverage the costs for the high-dose chemotherapy ("HDCT") and peripheral stem cell recovery procedures employed in the overall treatment of plaintiff's condition. Accordingly, defendant forthwith shall undertake to ascertain, process and pay either the appropriate provider to the extent it has not heretofore been paid by plaintiff, or, in the alternative, the plaintiff in the event she has advanced payment to the provider, any and all costs and charges for the HDCT and peripheral stem cell recovery procedures employed in the treatment of the plaintiff's cancer. To the extent defendant has not already been provided with an itemization of any claim for the procedures declared covered in this case, it forthwith shall make requests upon the providers of such services. To facilitate prompt compliance, plaintiff forthwith shall furnish defendant a list of all charges paid directly by the plaintiff. Defendant hereby is granted leave to then utilize its customary procedures for processing payment, provided that such customary procedures do not conflict with the requirements of this court's decision; and

5) Plaintiff shall have and recover against the defendant attorney's fees in the amount of $56,640.90 and costs in the amount $2,817.47.

6) This action hereby is ended and shall be removed from the active docket of the court.

Appendix C

The Clerk hereby is directed to forward a certified copy of this Order to all counsel of record.

ENTERED: _____

Judge

DATE: _____

APPENDIX D — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF VIRGINIA, CHARLOTTESVILLE DIVISION ENTERED JANUARY 22, 1996

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
CHARLOTTESVILLE DIVISION

CIVIL ACTION

NUMBER 94-0081-C

BY: B. Waugh Crigler
U.S. Magistrate Judge

NANCY MARTIN,

Plaintiff,

v.

BLUE CROSS AND BLUE SHIELD OF VIRGINIA,

Defendant.

ORDER

For the reasons set forth in the court's Memorandum Opinion of even date, it is

ORDERED

that plaintiff shall have until February 2, 1996 in which to file her petition for counsel fees together with evidence and a memorandum in support thereof. Defendant shall have until

February 16, 1996 in which to file countervailing evidence and any opposition to the petition. The court will decide the matter without oral argument.[1]

The Clerk of the Court is hereby directed to send a certified copy of this Order to all counsel of record.

ENTERED: _____

United States Magistrate Judge

_____

Date

---

1. The parties hereby are invited but are also not required to submit their respective proposals for the form of the final of order when they comply with the above briefing schedule. The submission of same shall not constitute a waiver by either side of any objection to the court's decision(s) in this case.

APPENDIX E — MEMORANDUM OPINION OF THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF VIRGINIA, CHARLOTTESVILLE DIVISION DATED JANUARY 22, 1996

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
CHARLOTTESVILLE DIVISION

CIVIL ACTION

NUMBER 94-0081-C

By B. Waugh Crigler
U.S. Magistrate Judge

NANCY MARTIN,

Plaintiff,

v.

BLUE CROSS AND BLUE SHIELD OF VIRGINIA,

Defendant.

MEMORANDUM OPINION

BACKGROUND

At the conclusion of the trial of this case on December 13, 1995, the court announced its findings and conclusions from the bench. Essentially it concluded that while the expenses for plaintiff's treatments were not excluded by any other term of the Summary Plan Description (SPD), the exclusion for

autologous bone marrow transplants (ABMT) should be construed to exclude the procedures employed in this case. However, because the court believed that it should revisit the law and reconsider the facts relating to this latter exclusion, the court granted plaintiff's oral motion to permit post-trial briefs on the matters relating to the ABMT exclusion.

In a nutshell, plaintiff submits that judgment should enter in her favor for three reasons. First, defendant failed to prove that the treatments plaintiff received were excluded and not covered under the terms of the SPD. Second, she argues that the decisional authority in the Fourth Circuit mandates a finding that the term ABMT does not include high-dose chemotherapy or peripheral stem cell support, which two treatment modalities, on their own, were covered under the SPD. Last, plaintiff contends that to the extent coverage criteria are established under the Comprehensive Group Policy, that policy already has been construed in this circuit to cover the chemotherapy and peripheral stem cell rescue components of the overall treatment plaintiff received.

Defendant, on the other hand, relies on the correctness of this court's initial impression about the triable issue, and offers that the court's findings at the conclusion of the trial were supported by the preponderance of the evidence. Specifically, defendant suggests that a decision in this case must rest on the facts produced at trial, and that the Fourth Circuit has not defined the meaning of the term ABMT as a matter of law. It offers that the cases cited in support of plaintiff's post-trial motion either do not address the precise issue now before the court or fail to establish the proposition offered by plaintiff as a matter of law. Accordingly, it asks the court to enter judgment in its favor based upon the initial findings and conclusions set forth from the bench the conclusion of trial.

Appendix E

SUPPLEMENTAL AND AMENDED FINDINGS AND CONCLUSIONS

At the outset, the court notes that it will not disturb its findings that plaintiff's treatment satisfied each of the defendant's policy treatment coverage guidelines (Joint Exhibit 16). Dr. Wolff's evidence was clear, unambiguous and much more believable to this court than the testimony of defendant's representative, Dr. Colley, and it will be credited over that of Dr. Colley. Moreover, the court's findings and conclusions that the procedures employed were not experimental or investigative will not be revisited or disturbed. The court believed at the time of trial, and it believes now, that the procedures employed under the circumstances of this case had become generally accepted in the field, were reasonable expected to be and were safe and efficacious, had demonstrated beneficial results and, therefore, neither were experimental nor investigative.

The only question the court is revisiting is whether the SPD exclusion for "Autologous or allogeneic bone marrow transplants except those that meet Blue Cross and Blue Shield of Virginia guidelines for coverage" excluded any or all the procedures employed to treat plaintiff's condition in this case. (Joint Exhibit 27, at 29 (Bates #000078)). The court originally answered that question in the affirmative, believing, though not expressly saying so on the record, that the decision by the Fourth Circuit Court of Appeals in *Hendricks v. Central Reserve Life Ins. Co.*, 39 F.3d 507 (4th Cir. 1994) required the court to conclude from the evidence that, because bone marrow transplants go hand-in-glove with high-dose chemotherapy and peripheral stem cell rescue, the term "autologous bone marrow transplant" as used in the SPD was sufficient to exclude all plaintiff's treatment modalities. Believing now that *Hendricks* requires nothing of

the sort, and further believing that even the court's initial approach to the true issues in this case was a bit off the mark, the court acknowledges its error and here attempts to correct it.

As stated from the bench, the term ABMT is loosely used within the medical profession to characterize both the single procedure of transplanting the bone marrow and the tripartite procedure that involves stem cell rescue, high-dose chemotherapy and the transplant itself. The evidence before the court shows that the transplant procedure, itself, ordinarily goes hand-in-glove with the others to better assure the success of the overall treatment. It further was clear from the evidence in this case that the high-dose chemotherapy would not have been undertaken without the other two components. However, it has never been disputed by defendant, and there also was evidence establishing, that neither the high-dose chemotherapy nor the stem cell rescue as separate procedures were excluded under the comprehensive policy, and certainly not under the SPD.

In *Doe v. Group Hospitalization & Medical Services*, 3 F.3d 80 (4th Cir. 1993), the Court of Appeals permitted fragmentation of the treatment components in determining whether an exclusion in a Blue Cross/Blue Shield plan for bone marrow transplants also eliminated coverage for high-dose chemotherapy and radiation therapy procedures related to the transplant, which separate procedures otherwise would have been covered under the plan there being considered. The court held that the bone marrow transplant exclusion was not broad enough to eliminate coverage for the other components of the claimant's overall treatment.

Hendricks involved a policy that contained exclusions similar to the ones at issue in this case for experimental and

investigative procedures and for ABMT's. The policy did not exclude high-dose chemotherapy as a separate treatment modality. The trial judge determined that participation by a claimant in what at that time amounted to a clinical trial of a multi-phase cancer treatment was, under the circumstance presented, experimental and investigative and, thus, excluded from coverage. The trial court did not reach the issue of whether the second exclusion also applied.

In affirming, the Fourth Circuit panel rejected the claimant's argument that the components of the procedures should be fragmented for purposes of determining whether the experimental and investigative exclusion obtains. It held that "to fragment the phases of treatment and consider each in light of the policy language produces an unrealistic and distorted analysis." 39 F.3d at 514.

The court's error on December 13, 1995 was to stop reading the opinion at that point and to focus solely on the above quoted portion of *Hendricks*, despite plaintiff's representations in her trial brief and at trial that *Hendricks* did not overrule *Doe*, and despite her suggestion that the instant exclusion should be construed to pertain only to one particular phase of the treatment process and not the process in its entirety. Two things are now more clear to the court. First, the evidence in *Hendricks* established that the entire process in which the claimant participated in November 1993 as considered by all, including the district judge to be a "clinical trial" of a multi-phase treatment regimen. Thus, the trial court did not fragment the components of the procedure before concluded that the entire regimen was experimental or investigative. The evidence here, however, was qualitatively different. In short, what was considered a clinical trial in November 1993 on the evidence

before the district judge in *Hendricks*, was not a clinical trial according to the preponderance of the evidence in this case. Instead, the procedure as a whole was an accepted modality for treatment of cancers like the one suffered by the instant plaintiff. The difference between the evidence in *Hendricks* and in this case is sufficient for this court to decline to apply the experimental and investigative exclusion, leaving, then, only the ABMT exclusion to consider.

Second, it is now clear to this court that *Doe* and *Hendricks* addressed separate exclusions in health care policies, and that they can be read congruently. Despite defendant's protestations to the contrary, the court believes it still may consider whether the SPD language excluding the ABMT should be more broadly applied to exclude the remaining phases which otherwise would be covered. As previously stated, DR. Wolff's testimony was sufficient to establish that the transplant, high-dose chemotherapy and peripheral stem cell rescue were interrelated procedures designed to better assure the success of plaintiff's treatment. Moreover, he conceded that the term ABMT, though it has a specific definition, often is used within the specialty to include the other two phases of treatment. However, his unrebutted testimony was that the ABMT is not the actual therapy, but that it is only a procedure that relates to the actual therapy. The actual therapy is the high-dose chemotherapy, and it has been undisputed in this litigation that neither the SPD nor the Comprehensive Group Policy itself explicitly excluded high-dose chemotherapy or the stem cell rescue from coverage. Both ordinarily were covered as separate procedures.

Believing it can fragment the treatment modalities under the circumstances here presented, and crediting plaintiff's evidence as the preponderance of the evidence, this court now

concludes that plaintiff's high-dose chemotherapy and peripheral stem cell rescue were not excluded under SPD, and that she is entitled to judgment declaring coverage for those procedures. By the same token, the court concludes that charges related to the autologous bone marrow transplant portion of plaintiff's treatment were excluded under the SPD, and that defendant is entitled to judgment declaring such.

Because this court does not desire to piecemeal a final order in this case, it will withhold entry of final judgment to allow plaintiff an opportunity to petition the court for counsel fees and to permit defendant an opportunity to oppose such petition. An order will enter accordingly.

The Clerk of the Court is hereby directed to send a certified copy of this Memorandum Opinion to all counsel of record.

ENTERED: _____

United States Magistrate Judge

_____

Date

APPENDIX F — MEMORANDUM OPINION OF THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF VIRGINIA, CHARLOTTESVILLE DIVISION DATED JULY 5, 1995

IN THE UNITED STATE DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
CHARLOTTESVILLE DIVISION

CASE NO.: 94-CV-81

July 5, 1995

NANCY MARTIN,

Plaintiff

-vs-

BLUE CROSS & BLUE SHIELD OF VIRGINIA,

Defendant

HEARD BEFORE:
THE HONORABLE B. WAUGH CRIGLER

* * *

(Thereupon, a recess was taken; following the recess, the Proceedings continued as follows:)

THE COURT: There are two issues for me to decide today. The first is whether or not the policy was received; that is to say the comprehensive group policy, which has been marked as an Exhibit, I think it is Number 30 in this case. Now, there have been substantial arguments made by the Defendant that with or

without the presumption the preponderance of the evidence would show that the policy was received, and that is Counsel on behalf of his client has developed a theory upon which he wishes the Court to conclude that the policy may have been destroyed after it was received. I am going to make a couple of observations in that regard. First of all, this policy is big enough to hardly miss if it comes in. It is no small policy page-wise.

The evidence before the Court is that the representative from Blue Cross/Blue Shield believes she mailed the entire package because of, primarily, two things. First of all, she normally does that, and, secondly, there is a checkmark showing that she did.

This is one of those rare instances that the Court doesn't have to resolve somebody's credibility. I don't have to determine whether somebody is telling the truth or not telling the truth in order to resolve this issue. I believe that the representative from Blue Cross/Blue Shield was truthful when she said she believes she mailed it. That is her belief, and I think it is an honest belief. Whether that occurred or not is a different question, and that doesn't call into account her credibility whatsoever. It calls into account whether factually something actually took place that you believe took place.

Now, the evidence from the plaintiff is certainly not strange to the Court in the way that things are done in small businesses. I have seen it case after case after case. Things that are important to the operation of the business are kept. Things that may not be important are not kept, particularly where you have a habit or practice of calling up people and communicating with people to get copies of things that you might need at a particular time.

I think it is entirely reasonable for this Plaintiff's company,

that is Ron Martin, Inc., to have operated its business the way it says it did. It kept some policies, didn't keep others. It wasn't important to them because they had access to agents and they had access to the telephone. It is entirely reasonable.

Now, whether Mr. Martin himself discharged his fiduciary relationship or duties is not an issue that I really need to resolve in this case and won't. Experience teaches the Court that when these policies are sold, the first question that is asked is, "Now, who is going to be the administrator?" "Well, I guess you are." Ninety-five percent of them are done that way. The testimony before the Court is that his administrative responsibilities were discharged by picking up the telephone, and that is entirely reasonable based on the circumstances of this case.

I find as a fact the policy was not delivered. I believe Ms. Drane when she said if it had been delivered, she would have known if it wasn't important to her, that the policies that they did have they kept, and that doesn't cause me to disbelieve the representative from Blue Cross/Blue Shield; it doesn't at all, but for this Court to believe that a company or a person can't make a mistake, even though you believe you haven't made a mistake is just asking the Court to do too much. I think on both sides I have had honest witnesses testify, because, you see, this boils down to a legal issue, not a factual issue with respect to whether the policy was delivered or not. That is to say it is not pitting Blue Cross versus Ron Martin, because you see there is a gap that the Court has to fill in by looking at the circumstantial evidence in the case.

Now, before I leave this issue I want to cover the presumption. If I was to apply the presumption as Defendant would want me to apply the presumption, there is no way in

creation that a party could ever overcome it, because it is impossible to prove a negative, but the circumstantial evidence of the case, including the credibility of the witnesses, leads me to believe that by a preponderance of the evidence, this policy did not make it to Ron Martin, Inc., whereas other things in the packet did. I don't know why; I don't have to determine why, but there is one thing I also need to say is that I am convinced beyond doubt that to think that it was destroyed somehow after receipt would be engaging in speculation, surmise, and conjecture, which this court is enjoined not to do.

There is not one iota of evidence that would support a finding that this policy was destroyed, because I believe on both sides we are dealing with honest people, just as I wouldn't say that the policy intentionally wasn't sent, because I don't believe that. I believe Blue Cross thought it sent the policy. Otherwise, I don't believe a person of this lady's qualifications and her training would be discharging the responsibilities that she does, Ms. Nash.

As I said, I don't have to determine why. I just have to determine whether, and I find in favor of the Plaintiff on that issue.

Now, the SPD issue is one that is more difficult, because there are serious legal questions that are raised by that, and if we look at Fuller & G[illegible]k and if we look at Aiken, and if look at Pierce and all of the [illegible]ies of cases out of the Fourth Circuit, and even if we look at Doe and Hendricks and all of those others that we have talked about, I don't think there is a single case that really has broached the issue like this one does, because what we have here by operation of law, I want to emphasize that, by operation of law, the SPD is the only thing that we have

to deal with because the policy was not delivered, and we have to deal with two things. What is the definition of reliance, and what is the definition of prejudice, and where do the burdens lie and the risks lie on each side of those issues?

Let me put it differently: Who has the burden of producing a clear SPD? I think the Fourth Circuit would say the insurance company. The next question is what is the responsibility of the participant or the insured where there has been a request for preapproval and it has been denied, and that is where the rubber meets the road in this case, because reliance is wrapped up in where the responsibility lies. Is the responsibility with the participant to stop the action and litigate the question of coverage while she dies, or is it okay to undergo procedures that are potentially life saving and which may or may not have saved her life in this case? I don't reach that, but she is certainly alive today, or do we go back to the insurance carrier who writes the SPD, which by operation of law has become the contract document in this case to be sufficiently clear as to alert a reader as to what is included and what isn't included, particularly in light of the way that this one is written, because exclusions are spelled out specifically.

Now, the testimony before the Court is this, and I alluded to it during argument, the representative from Blue Cross/Blue Shield told the Court in no uncertain terms that a reader of the SPD wouldn't know that this is not covered just from looking at the SPD. Now, that is what came out of a very honest person, and I appreciate that.

Now, nobody asked the question why, including the Court, and I think the reason is that that is a medical determination. I think the question boils down to one that the parties didn't

broach, and maybe there is a reason for it, and maybe you can tell the Court why, but I see a question of fact arising here as to whether the procedure that Mrs. Martin received was an ABMT or not an ABMT, as that term is defined by the SPD, which it says on Page 29, "Autologous or allogeneic bone marrow transplant, except those that meet Blue Cross/Blue Shield Virginia guidelines for coverage." Well, first of all, I would want to know whether it is an autologous or allogeneic bone marrow transplant.

MR. CARTER: Your Honor, it was a form of hematomatic —

THE COURT: But you know what, that doesn't help me.

MR. CARTER: Well, as we say in the letter to Blue Cross, that is a form that the doctors have referred to, either peripheral stem cell or the more traditional bone marrow transplant.

THE COURT: So are you telling the Court if the SPD excluded autologous, allogeneic bone marrow transplant, it excluded this particular procedure?

MR. CARTER: What I am saying is that it only at best could only exclude a support part, $5,000 worth of the procedure, just as —

THE COURT: Well, but how do I know that unless i take testimony from a doctor? You are a nice man. I trust you implicitly on legal matters, but I wouldn't count on what you tell me medically as far as I could throw you.

MR. CARTER: I understand that, Your Honor, but Doe does address that directly, and in here it says autologous —

THE COURT: But Doe is decided on evidence based on the policy, after all of the evidence is in, and we haven't taken one iota of evidence in this case medically.

MR. CARTER: That is correct, Your Honor.

THE COURT: You agree with that?

MR. CARTER: Yes, and the reason is we tried to bifurcate the contract.

THE COURT: I understand, but, unfortunately, it is creeping back in.

MR. CARTER: I think the position, though, Your Honor, is that it says autologous bone marrow transplants, except for those that meet Blue Cross/Blue Shield of Virginia guidelines for coverage. So that is still an ambiguity that Doe says you construe against the insurer.

THE COURT: That doesn't help me, either, because, you see, the exception may not have any bearing in this case if the facts show that it is an autologous or allogeneic bone marrow transplant as a matter of medical testimony, then you are out. The exception doesn't apply, period. If it is not, you are in, because I don't think that the law requires somebody to make a choice between their life and litigating or fighting over what the SPD says, if the SPD, as a matter of law, has become the contract. I don't think that is what the Courts are saying reliance is. I think the Courts are saying when you make your claim, what are you relying on? Where does your reliance lie? From what documents are you entitled to take your reliance in support of your position that you are owned this money, and here I have

found that as a matter of law, based on the facts that I have found, that the SPD replaced the contract.

So it does become one of fact as to whether this is an ABMT, but because we are also going to litigate the question of whether or not this is experimental because it might be excluded under another provision than this, then we are going to have all of that testimony at one time.

In short, the Plaintiff is still in the race, because I find that the policy did not reach the Plaintiff's company, and, secondly, because I find that unless this is an autologous, allogeneic bone marrow transplant that she underwent, then she would be entitled to coverage because the balance of it is ambiguous, because it refers to a document that was never delivered and the Plaintiff had the right not to have to go and inquire about all of these things before she chose life or death, and that is the finding of the Court.

MR. CARTER: Thank you, Your Honor.

MR. SPAHN: Thank you, Your Honor.

THE COURT: That is an interim ruling. I am not going to reduce it to anything yet.

MR. CARTER: We both realize this is sort of an unusual way to do it, and we really do appreciate it.

THE COURT: Let me tell you one thing, good lawyering is always a joy to have, and I think both sides have good Lawyers in this case, and I think they fought this hard, and I do think this is not over personalities. This is over a legal issue, and I can't

decide this case over personalities. I have got to decide it over legal issues, and when everybody understands that, it makes a whole lot better case, and I know the lawyers have.

MR. SPAHN: Your Honor, should we meet with your clerk or with you again to try to reschedule the rest of the case? We can do that at your convenience.

THE COURT: Yes, let's do that another day. I think we have really given it our all this afternoon.

MR. SPAHN: Thank you, Your Honor.

MR. CARTER: Thank you, again, Your Honor.

(Thereupon, the Proceedings were concluded)

APPENDIX G — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT DENYING PETITION FOR REHEARING FILED JULY 22, 1997

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 96-1534
CA-94-81-C

NANCY MARTIN

Plaintiff- Appellee

v.

BLUE CROSS & BLUE SHIELD OF VIRGINIA, INCORPORATED

Defendant - Appellant

On Petition for Rehearing with Suggestion for Rehearing In Banc

The appellee's petition for rehearing and suggestion for rehearing in banc were submitted to this Court. As no member of this Court or the panel requested a poll on the suggestion for rehearing in banc, and

As the panel considered the petition for rehearing and is of the opinion that it should be denied,

IT IS ORDERED that the petition for rehearing and suggestion for rehearing in banc are denied.

Appendix G

For the Court,
/s/ Patrick S. Connor
Clerk

APPENDIX H — STATUTORY PROVISIONS

28 U.S.C. § 1254. Courts of appeals; certiorari; certified questions

Cases in the courts of appeals may be reviewed by the Supreme Court by the following methods:

(1) By writ of certiorari granted upon the petition of any party to any civil or criminal case, before or after rendition of judgment or decree;

* * *

29 U.S.C. § 1001. Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce and the and the Federal taxing power

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans.

* * *

Appendix H

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

* * *

§ 1001b. Findings and declaration of policy

* * *

(c) Declaration of policy

It is hereby declared to be the policy of this title —

* * *

(3) to increase the likelihood that participants and beneficiaries under single-employer defined benefit pension plans will receive their full benefits;

* * *

Appendix H

29 U.S.C. § 1022. Plan description and summary plan description

(a)(1) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 1024(b)(1) of this title.

* * *

29 U.S.C. § 1024. Filing and furnishing of information

* * *

(b) Publication of summary plan description and annual report to participants and beneficiaries of plan

* * *

Publication of the summary plan descriptions and

annual reports shall be made to participants and beneficiaries of the particular plan as follows:

(1) The administrator shall furnish to each participant, and each beneficiary receiving benefits under the plan, a copy of the summary, plan description, and all modificatons and changes referred to in section 1022(a)(1) of this title —

(A) within 90 days after he becomes a participant, or (in the case of a beneficiary) within 90 days after he first receives benefits, or

(B) if later, within 120 days after the plan becomes subject to this part.

* * *

29 U.S.C. § 1102. Establishment of plan

(a) named fiduciaries

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

* * *

Appendix H

29 U.S.C. § 1103. Establishment of trust

* * *

(c) Assets of plan not to inure to benefit of employer; allowable purposes of holding plan assets

(1) Except as provided in paragraph (2), (3), or (4) or subsection (d) of this section, or under section 1342 and 1344 of this title (relating to termination of insured plans), or under section 420 of Title 26 as in effect on January 1, 1995) the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan.

* * *

29 U.S.C. § 1104. Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and —

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

* * *

29 U.S.C. § 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought —

(1) by a participant or beneficiary —

* * *

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

* * *

(3) by participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

* * *

Appendix H

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States all shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

* * *

(g) Attorney's fees and costs; awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

* * *

29 U.S.C. § 1133. Claims procedure

In accordance with regulations of the Secretary, every employee benefit plan shall —

(1) provide adequate notice in writing to any participant or

beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

(Pub.L. 93-406, Title I, § 503, Sept. 2, 1974, 88 Stat. 893.)

* * *

29 U.S.C. § 1135. Regulations

Subject to subchapter II of this chapter and section 1029 of this title, the Secretary may prescribe such regulations as he finds necessary or appropriate to carry out the provisions of this subchapter. Among other things, such regulations may define accounting, technical and trade terms used in such provisions; may prescribe forms; and may provide for the keeping of books and records, and for the inspection of such books and records (subject to section 1134(a) and (b) of this title).

(Pub.L. 93-406, Title I, § 505, Sept. 2, 1974, 88 Stat 894.)

* * *

Appendix H

29 C.F.R. 2560.503-1.

Sec. 2560.503-1 — Claims procedure.

* * *

(f) Content of notice. A plan administrator or, if paragraph (c) of this section is applicable, the insurance company, insurance service, or other similar organization, shall provide to every claimant who is denied a claim for benefits written notice setting forth in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the denial;

(2) Specific reference to pertinent plan provisions on which the denial is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(4) Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.

(g) Review procedure.

(1) Every plan shall establish and maintain a procedure by which a claimant or his duly authorized representative has a reasonable opportunity to appeal

a denied claim to an appropriate named fiduciary or to a person designated by such fiduciary, and under which a full and fair review of the claim and its denial may be obtained. Every such procedure shall include but not be limited to provisions that a claimant or his duly authorized representative may:

(i) Request a review upon written application to the plan;

(ii) Review pertinent documents; and

(iii) Submit issues and comments in writing.

(2) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such company, service organization. In such case, that company, service, or organization shall be the "appropriate named fiduciary" for purposes of this section may be the plan administrator or any other person designated by the plan, provided that such plan administrator or other person is either named in the plan instrument or is identified pursuant to a procedure set forth in the plan as the person who reviews and makes decisions on claim denials.

* * *